| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155567 | A. BUILDING _____ B. WING _____ | R-C 01/15/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **UNIVERSITY PARK HEALTH AND REHABILITATION CENTER** | **1400 MEDICAL PARK DR FORT WAYNE, IN 46825** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS | {F 000} | | |

This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00160064 completed on December 5, 2014.

This visit was in conjunction with the PSR to the Recertification and State Licensure Survey completed on December 5, 2014.

This visit was in conjunction with the PSR to the Investigation of Complaint IN00158970 completed on November 13, 2014.

Complaint IN00160064 -Corrected

Complaint IN00158970 -Corrected

Survey dates: January 14 & 15, 2015

Facility number: 000459
Provider number: 155567
AIM number: 100289700

Survey team:
Rick Blain, RN - TC
Tim Long, RN
Carol Miller, RN
Diane Nilson, RN

Census bed type:
SNF: 2
SNF/NF: 57
Total: 59

Census Payor type:
Medicare: 8
Medicaid: 41
Other: 10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **UNIVERSITY PARK HEALTH AND REHABILITATION CENTER** | **1400 MEDICAL PARK DR FORT WAYNE, IN 46825** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | Continued From page 1<br>Total: 59<br><br>Sample: 6<br><br>University Park and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the PSR to the Investigation of Complaint IN00160064 and the PSR to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaint IN00158970.<br><br>Quality review completed on January 16, 2015 by Randy Fry RN. | {F 000} | | |